

# Quality of Life in the Nursing Home: Perspectives of Younger and Older Residents

Ashli Watt and Candace Konnert  
Department of Psychology, University of Calgary

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## RÉSUMÉ

Les adultes âgés de 65 ans et moins forment une partie importante des résidents des centres d'hébergement de soins de longue durée. Jusqu'à maintenant, toutefois, aucune recherche n'examine leur qualité de vie, y compris de quelle façon leurs perceptions de la qualité de vie se comparent à celles des résidents plus âgés de ces centres. La présente étude a employé une approche multidimensionnelle pour évaluer la qualité de vie des résidents plus jeunes de ces centres d'hébergement et sa relation avec la santé, le soutien social, et les loisirs; et elle compare la qualité de vie des résidents plus jeunes et plus âgés. L'échantillon comprenait 43 résidents plus jeunes ( $M = 53,7$  ans) et 38 résidents plus âgés ( $M = 79,92$  ans). Les résultats indiquent qu'il n'y avait aucune différence d'âge en ce qui a trait à la qualité de vie, et suggèrent qu'il faut une conceptualisation élargie de la qualité de vie de la population des centres d'hébergement de soins de longue durée.

## ABSTRACT

Adults aged 65 and younger make up a significant proportion of nursing-home residents. To date, however, there is no research examining their quality of life (QOL), including how their perceptions of QOL compare to those of older nursing-home residents. This study used a multidimensional approach to (a) assess the QOL of younger nursing-home residents and its relationship to health, social support, and leisure activities; and (b) compare the QOLs of younger and older residents. The sample consisted of 43 younger residents ( $M = 53.7$  years) and 38 older residents ( $M = 79.92$  years). Results indicate that there were no age differences in QOL, suggesting the need for a broad conceptualization of QOL in the nursing-home population.

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Correspondence regarding this article should be sent to :

Candace Konnert, Ph.D.  
Department of Psychology  
University of Calgary  
2500 University Drive NW  
Calgary AB T2N 1N4  
(konnert@ucalgary.ca)

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Research on quality of life (QOL) in nursing homes has focused on older residents (Kane et al., 2003; Sloane et al., 2005). Often ignored is the fact that younger adults account for approximately 10 per cent of the nursing-home population (Tilly, Goldenson, & Kasten, 2001). This percentage will increase because medical advances have enabled the lives of people with chronic physical disabilities to be prolonged. To date, there is no research investigating the QOL of younger nursing-home residents. Yet, there are unique threats to the QOL of these residents.

Institutional living can be difficult at all ages, as residents are physically separated from loved ones and may experience a decline in social support, a loss of perceived control due to the nature of institutional living, and a reduction in access to activities, particularly activities that involve leaving the facility. Moreover, such problems may be even more difficult for younger residents, as residing in a nursing home is a non-normative experience for younger adults and the institutional milieu is typically designed for older adults.

Several multidimensional models have been developed for assessing QOL among older adults (e.g., Kane et al., 2003; Lawton, 1991). A particularly promising approach is the Being, Belonging, and Becoming (BBB) model, which has the added advantage of being widely applicable to adolescents, community-dwelling older adults, nursing-home residents over the age of 65, and people with disabilities, among others (Raphael, Renwick, Brown, & Rootman, 1994; Stelmach, 2005). The BBB model focuses on three broad fundamental areas of life—being, belonging, and becoming—and each of these has three sub-components. *Being* refers to the most basic aspects of who one is and is composed of *physical* being (e.g., body and health), *psychological* being (e.g., feelings, cognitions, and evaluations of the self), and *spiritual* being (e.g., beliefs and values). *Belonging* refers to environmental fit and is composed of *physical* belonging (e.g., connection to surroundings), *social* belonging (e.g., links to social environments), and *community* belonging (e.g., access to community resources). *Becoming* focuses on purposeful and goal-oriented activities and is composed of *practical* becoming (e.g., practical, purposeful activities), *leisure* becoming (e.g., activities that promote relaxation and stress reduction), and *growth* becoming (e.g., activities to maintain or improve knowledge and adaptation to change). Thus, the BBB model focuses on nine separate dimensions of QOL and acknowledges that adequate assessment of QOL must attend both to the importance individuals attach to each dimension and to their perceived satisfaction with that dimension. The BBB model is a promising approach to investigating QOL in younger nursing-home residents because it taps many of the domains that have been found to be important for QOL among younger adults with chronic physical disabilities living in the community (e.g., Gulick, 1997).

The purposes of this study were as follows: (a) to assess the QOL of nursing-home residents under the age of 65 using two measures of QOL, one using the BBB model, and the other a more established measure, the Life Satisfaction Index-A (LSI-A) (Adams, 1969); (b) to examine correlates of QOL, specifically indices of health, social support, and leisure activities, all of which have been shown to be important correlates among individuals with physical disabilities living in the community; and (c) to assess differences in QOL between younger (65 years and younger) and older (older than 65) residents. It may be that younger and older residents have different needs in terms of enhancing QOL and may require different types of policies and programming. To date, there are no studies that have examined QOL among younger nursing-home

residents or age differences in QOL within the nursing-home setting.

## Method

### Participants

Younger and older residents were recruited from a public, not-for-profit, 278-bed nursing home in Calgary. The nursing home has six units, each located in a separate wing within the facility. Three of the units house a total of 147 younger adults, and admission to these units is based on age (65 years and younger) and disability status, typically traumatic injuries (e.g., spinal cord injury) or progressive disorders (e.g., multiple sclerosis). Each unit contains a separate eating and recreational area. Additionally, there are common areas and activities for all residents in the facility. The philosophy of care and institutional policies are similar across units for both older and younger residents.

### Younger Residents

Forty-three residents were recruited. Exclusionary criteria were (a) over the age of 65; (b) moderate to severe cognitive impairment, as indicated by a score of less than 20 on the Mini-Mental Status Examination (MMSE) (Folstein, Folstein & McHugh, 1975) as recommended by Smith, Magill-Evans, and Brintnell (1998); (c) too physically ill to participate in the study; (d) lived in a nursing home less than 6 months, and (e) unable to communicate.

### Older Residents

Thirty-eight residents (over age 65) were recruited. With the exception of age, all other exclusionary criteria were identical to those used for younger residents. Data for these residents were part of a larger study of QOL in nursing care (Stelmach, 2005).

### Procedure

#### Younger and Older Residents

Participants were recruited with the assistance of the research liaison staff member for the facility. Informed consent was obtained, and residents were interviewed privately, often over multiple sessions, no longer than 45 to 60 minutes at a time in order to avoid undue fatigue or accommodate residents' commitments. All measures were administered verbally to accommodate for vision loss and motor problems. In cases of severe expressive aphasia, devices were used to facilitate the interview (e.g., talking computers, letter boards to spell responses).

## Measures

### Younger Residents

Participants provided demographic information and were interviewed with a protocol that included the self-report measures that follow.

Quality of life was assessed using the Quality of Life Profile: Version for Persons with Physical and Sensory Disabilities (QOLP-PD) (Renwick, Nourhaghighi, Manns, & Rudman, 2003) and the LSI-A (Adams, 1969). The LSI-A was included because it has been used extensively with individuals with physical disabilities and with nursing-home residents and is more established than the QOLP-PD.

The QOLP-PD consists of 55 items and assesses the nine dimensions of the BBB model in adults with chronic disabilities. It yields both a total score and a score for each of the nine sub-scales. One of the sub-scales consists of seven items, while the remaining eight sub-scales consist of six items each. Each item is scored according to its level of importance to the participant (1 = *not important at all*; 5 = *extremely important*) and the participant's level of satisfaction (1 = *not at all satisfied*; 5 = *extremely satisfied*). Thus the measure provides information about both perceived importance and satisfaction with each component. A basic score is calculated for each item by applying the following formula:  $3[(\text{importance score}/3) \times (\text{satisfaction score} - 3)]$ . The basic score takes importance ratings into account when looking at satisfaction ratings. The basic scores for items in each sub-scale are summed and divided by the number of items in this sub-scale to provide an overall rating for the sub-scale. The basic sub-scale scores can range from -10 (*not at all satisfied with extremely important issues*) to 10 (*extremely satisfied with extremely important issues*) (Renwick, Rudman, Raphael, & Brown, 1996).

Test-retest reliability of responses to the QOLP-PD has been reported as  $r=0.82$  over a 6-month interval (Centre for Health Promotion, 1993; R. Renwick, Personal communication, 19 December 2006). In this study, internal consistency estimates were  $\alpha=0.95$  for the total scale and ranged from  $\alpha=0.64$  (practical becoming) to  $\alpha=0.87$  (psychological being) for individual sub-scales (basic scores). Only responses to the practical becoming sub-scale failed to demonstrate good internal consistency. The responses to the QOLP-PD demonstrated adequate content validity with younger nursing-home residents (Watt, 2003). Convergent validity of responses was demonstrated by a strong correlation between the QOLP-PD and the LSI-A ( $r=0.70$ ;  $p<0.01$ ).

The LSI-A is an 18-item measure of QOL. Scores range from 0 to 18, with lower scores representing lower QOL. In this study, the internal consistency was measured as  $\alpha=0.82$ .

Perceived physical health was rated as excellent, good, fair, or poor using a single item (Maddox & Douglas, 1972). Scores ranged from 1 to 4, with higher scores indicating poorer health.

Functional health was assessed with the Minimum Data Set (MDS) for Nursing-Home Resident Assessment and Care Screening (Morris et al., 1990). Six MDS-ADL items are rated on a 4-point Likert scale and scores range from 0 to 24, with higher scores indicating more functional dependence. In this study, the internal consistency of responses was measured as  $\alpha=0.89$ .

Pain was assessed with a single 11-point (0–10) item (NRS-11), with 0 indicating *no pain* and 10 indicating the *worst pain imaginable* (Farrar, Young, LaMoreaux, Werth, & Poole, 2001).

Mental status was assessed with the MMSE (Folstein et al., 1975), a 30-item measure of cognitive functioning, with lower scores indicating more impairment.

Social support was assessed by a frequency-of-visitation measure (1 = *daily* to 7 = *less than once a month*) and a categorical rating of the presence or absence of a confidant relationship.

Leisure activities were assessed by asking residents about how frequently they engaged in activities and how often they left the nursing home. Frequency of activities and frequency of outings were measured on a 7-point Likert scale (*daily, 5–6 times per week, 3–4 times per week, 1–2 times per week, once every couple of weeks, once a month, or less than once a month*).

### Older Residents

Older residents completed the same measures of perceived and functional health and mental status as their younger counterparts, as well as the LSI-A and the Quality of Life Profile: Seniors Version (QOLP-SV) (Raphael, Renwick & Brown, 1996), also based on the BBB model. A few items on the QOLP-PD were modified slightly so that there were equivalent versions for group comparisons.

Responses to the QOLP-SV have shown excellent internal consistency in both community-dwelling older adults ( $\alpha=0.95$ ) and nursing-home residents ( $\alpha=0.95$ ) (Raphael, Brown, Smith, & Renwick, 1998; Stelmach, 2005). In nursing-home samples, the QOLP-SV is strongly correlated with the LSI-A ( $r=0.66$ ,  $p<0.01$ ) (Stelmach, 2005).

## Results

### Plan for Analysis

To assess QOL among younger residents, basic scores (a rating that combines importance *and* satisfaction) for both the total scale and for each of the nine sub-components of the QOLP-PD were examined, as were the total scores from the LSI-A. To determine the specific correlates of QOL for younger nursing-home residents, the nine sub-components of the BBB model (measured by the QOLP-PD), as well as the independent measures of perceived physical health, functional health, pain, social support (i.e., frequency of visitors; presence/absence of a confidant), and leisure activities (i.e., frequency of involvement in activities; frequency of leaving the nursing home) were correlated with the LSI-A. To examine age differences in QOL, independent *t* tests were performed on total QOLP-SV and LSI-A scores and on the nine sub-components of the QOLP-SV.

### Participants

#### Younger Residents

All younger residents were Caucasian, with the exception of one who was Asian. Mean age of younger residents was 53.70 years ( $SD = 7.46$ ; range = 25 to 64); 51.2 per cent were male; most were single (30.2%), married (32.6%), or divorced (25.6%); and the majority had completed high school or beyond (72.2%). Perceived health was rated as *excellent* or *good* by 55.8 percent of respondents, followed by *fair* (25.6%) and *poor* (18.6%). The types of disabilities included multiple sclerosis (51.2%) and traumatic brain injury or stroke (23.2%). The average MDS-ADL score was 13.35 ( $SD = 7.95$ ) and average pain ratings were 3.08 out of 10 ( $SD = 3.16$ ). Mean MMSE score was 26.52 ( $SD = 2.78$ ).

#### Older Residents

All older residents were Caucasian. Mean age was 79.92 years ( $SD = 8.08$ , range = 66 to 97); 65.8 per cent were female; most were either widowed (57.9%) or married (21.1%), and the majority had completed high school or beyond (68.5%). Perceived health was rated as *excellent* or *good* by 39.5 per cent of respondents, followed by *fair* (34.2%) and *poor* (26.3%). The average MDS-ADL score was 9.61 ( $SD = 5.80$ ), and the average MMSE score was 25.03 ( $SD = 3.46$ ). Pain ratings were not available for older residents.

Table 1 presents social support and leisure activity data for younger residents. Particularly noteworthy was the finding that 21 per cent of younger residents received visits once a month or less and one third did not have a confidant relationship. Also, 20.9 per cent of younger residents were involved in activities less

**Table 1: Social support and leisure activities among younger residents ( $n = 43$ )<sup>a</sup>**

	n	%
<b>Frequency of Visitors</b>		
Daily	5	11.6
5–6 times per week	2	4.7
3–4 times per week	8	18.6
1–2 times per week	17	39.5
Once every couple of weeks	2	4.7
Once a month	6	14.0
<Once a month	3	7.0
<b>Presence of a Confidant Relationship</b>		
Yes	28	65.1
No	15	34.9
<b>Frequency of Involvement in Activities</b>		
Daily	14	32.5
5–6 times per week	2	4.7
3–4 times per week	12	27.9
1–2 times per week	6	14.0
Once every couple of weeks	0	0
Once a month	0	0
<Once a month	9	20.9
<b>Frequency of Leaving the Nursing Home</b>		
Daily	2	4.7
5–6 times per week	0	0
3–4 times per week	4	9.3
1–2 times per week	13	30.2
Once every couple of weeks	5	11.6
Once a month	3	7.0
<Once a month	16	37.2

<sup>a</sup> Some percentages may not sum to zero due to rounding error.

than once a month, while 44.2 per cent left the facility once a month or less.

### Quality of Life of Younger Residents

The mean score on the LSI-A was 8.19 ( $SD = 4.24$ ). The mean score in the general population (ages 18 to 64) has been reported as 13.35 (Harris & Associates, 1975). Possible overall QOL scores on the QOLP-PD can range from 10 (*not at all satisfied with extremely important issues*) to 10 (*extremely satisfied with extremely important issues*). In this sample, the mean score was 1.15 ( $SD = 2.12$ ), indicating that younger residents were somewhat satisfied with their QOL. Table 2 shows the rank ordering of mean basic scores and descriptive data for sub-scales of the QOLP-PD.

### Correlates of Quality of Life

As was expected, the total QOLP-PD score and the LSI-A were strongly correlated ( $r[42] = 0.70$ ;  $p < 0.01$ ), suggesting concurrent validity of responses to the QOLP-PD. In addition, all nine sub-scales of the QOLP-PD were moderately correlated with the LSI-A,

**Table 2: Descriptive data for the basic scores of the QOLP-PD for younger residents (n = 42)**

Basic Score	M	SD	Range
Physical Belonging	1.83	2.91	-8.33 to +8.00
Spiritual Being	1.74	2.92	-4.00 to +6.83
Growth Becoming	1.49	2.51	-4.17 to +6.17
Psychological Being	1.33	3.52	-5.33 to +9.17
Social Belonging	0.95	2.85	-3.33 to +8.33
Leisure Becoming	0.63	2.41	-6.50 to +6.00
Practical Becoming	0.62	2.03	-3.86 to +4.00
Physical Being	0.55	2.85	-5.50 to +7.50
Community Belonging	0.50	2.32	-7.17 to +3.83

with correlations ranging from  $r = 0.47$  ( $p < 0.01$ ) to  $r = 0.60$  ( $p < 0.01$ ). To determine the relationships between QOL (i.e., the LSI-A) and the hypothesized contributing factors, zero-order correlations were calculated. Younger residents with better perceived health and lower levels of pain reported higher LSI-A scores, as did younger residents who had higher rates of visitation and confidant relationships. Correlations were moderate and ranged from  $r = 0.35$  ( $p < 0.05$ ) to  $r = 0.40$  ( $p < 0.05$ ).

#### *Comparisons between Younger and Older Residents' Quality of Life*

Independent *t* tests were used to compare responses of younger and older residents to the LSI-A, the total QOLP-SV score, and on each of the nine sub-scales of the QOLP-SV. Mean scores for older residents were 9.52 ( $SD = 4.02$ ) for the LSI-A, 1.30 ( $SD = 1.88$ ) for the QOLP-SV, and ranged from -0.31 on the physical being sub-scale to 1.89 on the social belonging sub-scale. There were no significant differences between groups on any of the QOL measures.

## **Discussion**

### *Quality of Life of Younger Residents*

The first goal of this study was to investigate QOL in younger nursing-home residents. Results suggest that the QOLP-PD is an assessment instrument worthy of future research and use with this population. Conceptually, it recognizes that QOL has physical, psychological, and spiritual dimensions; that individuals need to belong, in both a physical and a social sense; and that individuals need to distinguish themselves by pursuing their own goals, whatever their circumstances in life. Responses to the QOLP-PD showed poor to good internal consistency, both for the overall measure and for all but one sub-scale, practical becoming, and good convergent validity of responses with the LSI-A, a well-established measure of QOL

among younger adults with disabilities. Most importantly, the QOLP-PD goes beyond the typical QOL assessments in nursing homes, which are often too general and disease-specific, neglecting social, psychological, and spiritual dimensions.

Ratings of the belonging components varied, depending on which sub-component was assessed. Physical belonging was rated highest, indicating that younger residents felt connected to their environments in terms of qualities such as safety, privacy, comfort, adequacy of space, and physical accessibility. This finding is somewhat surprising given that nursing-home environments are often criticized for the lack of privacy and the limited space associated with shared accommodation. Rated lower were the sub-components of social belonging and community belonging, suggesting that younger residents feel somewhat disconnected from friends, relatives, other residents, and social events. In addition, they reported feeling detached from resources, places, and events in the broader community outside of the nursing home. This result is consistent with the finding that over one third of younger residents (37.2%) reported leaving the nursing home less than once a month and approximately the same number were without a confidant (34.9%). Past research clearly indicates that the absence of a confidant is related to higher levels of depression (Murphy, 1982) and lower life satisfaction (Chappell & Badger, 1989).

With respect to the being components, younger residents rated their spiritual being and psychological being higher than their physical being. This suggests that, in spite of physical and functional limitations and lower QOL in these areas, they were relatively more content with the psychological and spiritual aspects of their lives. Psychological being focuses on self-acceptance, autonomy, mood, and a positive attitude towards oneself and life in general. Spiritual being reflects not just spiritual or religious beliefs but also being at peace with oneself, feeling that one's life has purpose, feeling optimism about the future, sharing love, and having a clear sense of right and wrong. These results support those of Kane et al. (2003) with older nursing-home residents, who contend that the assessment of QOL must attend to multiple domains. All too often, QOL measures over-emphasize physical and functional health in accordance with the medical model that is prevalent in virtually all nursing homes and neglect the psychological, social, and spiritual components of health. Moreover, the findings of this study support the notion of resilience, characterized by "good outcomes in spite of serious threats to adaptation or development" (Masten, 2001, p. 228). Clearly younger residents live in difficult circumstances and contend

with the multiple challenges of chronic disease. Yet, consistent with compensatory models of development and functioning, they are able to maintain better QOL in those domains over which they may have greater control (i.e., psychological and spiritual domains).

Of the three becoming sub-components, the highest QOL ratings were for growth becoming. In contrast to leisure becoming and practical becoming, which are more dependent on external factors (e.g., opportunities in the broader community), growth becoming focuses on internal processes (e.g., adaptation, interpersonal skills, etc.). These results support the idea that QOL ratings are highest in those areas over which younger residents have the most control (i.e., those areas that involve internal processes that are not heavily dependent on external factors). Achieving a good QOL in these circumstances may involve selectively focusing on those areas where growth is possible. Models within the aging literature have emphasized the importance of optimizing internal control when external control decreases (Schulz & Heckhausen, 1996). It appears that these processes may be equally relevant to younger adults living in nursing homes.

Two additional factors may account for the apparent resilience of some younger residents. First, social comparison processes influence evaluations of QOL (Diener & Fujita, 1997). Although younger residents in this sample were experiencing poor health, they were doing relatively well compared to those who could not participate. It may be that some younger residents were engaging in downward social comparison with those who had lower functional levels, thereby preserving their perceived QOL. In support of this, Groomes and Leahy (2002) found that coping among adults with disabilities was characterized, in part, by cognitive restructuring (e.g., saying things like, "[T]here are people worse off than me"). By doing so, they were able to maintain a positive outlook.

Second, optimism is related to life satisfaction (Lyubornirsky, 2001) and is especially important in difficult circumstances or situations of long-term institutionalization (Schneider, 2001). Realistic optimism (otherwise known as making the best of it) involves focusing on the favourable aspects of the situation. This attitude was reported in an ethnographic study of older nursing-home residents (Kahn, 1999) and may be an attitude that is adopted by younger residents as well.

#### *Correlates of Quality of Life*

The second goal of this study was to examine factors related to QOL. Higher QOL was related to

better perceived physical health, lower pain, greater frequency of visitors, and the presence of a confidant.

#### *Physical Health*

What is noteworthy about these findings is that functional health was not correlated with QOL. A common perception is that the more functionally dependent one is on others for daily care, the more QOL must suffer. Based on this assumption, QOL is frequently assessed in the context of rehabilitation research by measuring functional status in one or more areas. The results of this study, however, suggest that it was younger residents' perceived health and pain that were related to scores on the LSI-A. This is consistent with the literature on adults with spinal cord injury, where perceived health was consistently related to QOL (e.g., Boschen, 1996), and with the multiple sclerosis literature, where relationships between QOL and pain ratings, but not functional abilities were found (e.g., Gulick, 1997). Taken together, these findings suggest that using functional health ratings as a proxy for QOL is not appropriate. In contrast, unrelieved pain has repeatedly been linked to lower QOL and poorer mental health (Casten, Parmalee, Kleban, Lawton, & Katz, 1995; Skevington, 1998). Thus, efforts to alleviate chronic and persistent pain would go far towards improving the QOL of younger residents.

#### *Social Support*

Social ties are important for QOL and institutionalization puts individuals at risk for reduced support. One quarter of younger residents recruited for this study received visits less than once a week, and those who were visited more often reported better QOL. Similarly, Thompson and Heller (1990) found that fewer nursing-home visits were related to lower perceived social support and poorer mental and physical health outcomes. While visitation is important, having a confidant provides emotional support that, in this study, was related to better QOL. These results are consistent with those of Chappell and Badger (1989) in the general population and Strain and Chappell (1982) in a nursing-home sample.

#### *Differences and Similarities in the QOL of Younger and Older Residents*

The third goal of this study was to examine whether differences existed between the QOL of younger and older residents. Institutional policies and programs tend to adopt a one-size-fits-all approach to promoting QOL, in spite of the presence of diverse age groups. Moreover, life-span developmental theory

would lead us to expect that, because relocation to a nursing home as a young or middle-aged adult is a non-normative experience, younger adults may feel out of sync with their age peers and experience a poorer QOL. The results of this study did not support this expectation.

#### *Limitations of the Research*

The sample recruited for this study was small (restricted to one nursing home) and likely was characterized by selection biases. Examining the exclusionary criteria more closely, the most common reason for exclusion among younger residents was the inability to communicate (15.5%), and 6.8 per cent of those approached were excluded because of low MMSE scores. Thus, younger residents with higher levels of functioning were more likely to participate. In addition, the sample was not ethnically diverse, and those from different ethnic backgrounds are likely to be at greater risk for poor QOL, particularly if English is not their first language. Excluding these groups may have resulted in an overly positive view of younger residents' QOL.

In addition, age comparisons were confounded by other factors, including gender, marital status, and chronic illness. Older residents were more likely to be female and widowed, with multiple chronic illnesses, while younger residents were evenly split with respect to gender, were rarely widowed, most often had multiple sclerosis, and rated their functional health significantly more poorly ( $p < 0.01$ ). Thus age comparisons neglected other, potentially important participant characteristics. Moreover, the younger residents in this study were recruited from young adult units, and this may have influenced their QOL. Future research should address whether there are differences in QOL between young adults who reside in age-integrated units and those who reside in age-segregated units.

#### *Practice Implications and Future Research*

What clearly emerges from this research is the importance of a multidimensional approach to meeting the QOL needs of this population, rather than simply focusing on physical needs. While this may seem obvious, the medical orientation of most nursing homes makes the importance of a holistic approach worth emphasizing. Information from this study can be used to inform institutional policies, to allocate resources, and in program planning. For example, institutional policies and practices should encourage and support family involvement and promote social ties to the broader community. The challenges for program development and implementation are

two-fold: first, how best to meet the QOL needs of a population that is diverse in terms of both functional ability and interests; and second, how to do so in institutional environments that are often resource-poor. On a broader level, other QOL models should be explored in this population. For example, Lindstrom (1992) incorporates a unique global dimension that includes issues such as human rights and social welfare policies. Clearly these are factors that have a strong, yet more distal, influence on younger residents' QOL.

Finally, some younger residents were clearly able to maintain a high QOL in spite of adversity. Response-shift theory proposes that significant life changes (e.g., health decline) prompt behavioural, cognitive, and affective processes with the potential to create a shift in an individual's standard of what is important to achieving a good QOL (Spranger & Schwartz, 1999). A better understanding of these processes and of the contribution of variables such as resilience and optimism in preserving QOL are fruitful areas for further research.

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